CENTRAL CITY CONCERN
HOMES HEALTH JOBS

IMANI CENTER REFERRAL FORM

2040 SE Powell Blvd, Portland OR 97202
Phone: (503) 226-4060
Email: ImaniCenter@ccconcern.org Fax: (503) 445-0749

Today's date:	**PLEASE PRINT LEGIBLY OR TYPE**

PARTICIPANT INFORMATION

Client's name:		DOB:
Gender identification:		Race Identification:
Address: (mailing)		City, State, Zip
Homeless Y or N	How long have you been homeless?	
Phone:		Message Phone:
Insurance Carrier:	PCP:	Location & Phone #:

Type of Services needed: Mental Health / Alcohol & Drug	MH ☐ A&D ☐	
If you currently involved with DHS or DCJ? If yes complete on right side →→→ →→→	☐ Y ☐ N	DHS / DCJ contact information:
Are you currently receiving services at CCC or another agency? If yes where, when, complete on right side →→→	☐ Y ☐ N	Other Agency information
Do you know anyone who works here or is receiving services here? If yes who?	☐ Y ☐ N	Patient Medications:
Reason For Referral:		

REFERRING AGENCY INFORMATION
(Attach Release of Information (ROI) for notification of client status

Referred from:	
Contact Person:	Phone#:

Will the referent continue to be involved with the client after this referral? If so, how?